THE VERMONT STATE

SYSTEM OF CARE PLAN

FOR

CHILD, ADOLESCENT AND FAMILY MENTAL HEALTH

STATE FISCAL YEARS 2005-2007



Vermont State Department of Developmental and Mental Health Services
Division of Mental Health
Child, Adolescent and Family Unit

April 2004

PURPOSE OF THIS PLAN

The Vermont State System of Care Plan for Child, Adolescent and Family Mental Health focuses on the vision, current reality, and three-year priorities for development of the public mental health system, which in Fiscal Year 2003* served over 9,500 people under age 22.

This document aims to provide all citizens a better understanding of:

- what the Child, Adolescent and Family Unit (CAFU) of the Division of Mental Health (DMH) is trying to accomplish in collaboration with Designated and Specialized Service Agencies;
- how the system of care serves Vermonters;
- how dollars from taxpayers and other sources are used;
- the level of resources necessary to support current services and, when possible, to develop services and capacities for needs still unmet; and
- the priorities for the three years from State Fiscal Year 2005 to State Fiscal Year 2007 (July 1, 2004-June 30, 2007).

This *Plan* presents a more in-depth picture of the children's mental health system than that described along with child welfare, education and other services in the interagency *Vermont System of Care Plan for Children and Adolescents with a Severe Emotional Disturbance and Their Families.*

* Endnotes are located in Appendix D, page 43.

TABLE OF CONTENTS

SECTION IV:

SECTION I:

THE VISION:

WHERE WE WANT TO GO

VISION AND MISSION
Child, Adolescent and Family Unit
Division of Mental Health

VISION:

All children and families are emotionally healthy.

MISSION:

To assure timely delivery of effective prevention, early intervention, and behavioral/emotional health treatment and supports through a family-centered system of care for all children and families in Vermont.

DESIRED OUTCOMES FOR FOUR DOMAINS OF QUALITY SERVICE:

- **Access**
  The five Core Capacity Services (page 11) are available to children and families in need.

- **Practice Patterns**
  Services provided are appropriate, of high quality, and reflect current best practices.

- **Outcomes/Results of Treatment**
  The quality of life improves for children and families served.

- **Structure/Administration**
  Designated and Specialty Agencies will be fully functional, and have strong working relationships with the Vermont State Department of Developmental and Mental Health Services, families, and other stakeholders.

PRIORITY STRATEGIES:

- **Family Involvement, Participation, and Empowerment**
  Ensure that families are valued and involved at all levels of the system of care.

- **Partnerships**
  Develop and maintain as many partnerships with contributors to the system of care as possible.

- **Effective Management of Care**
  Monitor and improve outcomes through program reviews, quality improvement plans, and agency designation.

- **Expansion of attitudes, knowledge, and skills**
  Promote awareness and use of best practices about the emotional and behavioral health treatment of children through education, training, technical assistance, and consultation for/with children's mental health staff, key stakeholders and the general public. Use and promote principles and tools of continuous quality improvement.

- **Effective working relationships**
  Foster respect for children and youth, families, stakeholders, staff, and community members.

PRINCIPLES

The following are **guiding principles** for the Vermont system of care for children and adolescents who are experiencing or at risk for experiencing mental health challenges and their families.

1. The system works from a strengths-based and holistic approach to the child and family.

2. Early identification, assessment, and intervention services should be available to families to enhance the likelihood of positive outcomes.

3. Child-centered, family-focused treatment and support can best be delivered through an individual treatment plan developed with child and family input.

4. Children and adolescents should receive services within their family home or the most family-like environment appropriate to meet their needs.

5. Respectful services should foster enduring family relationships regardless of where children are living.

6. Children and adolescents have the right to receive appropriate services without having parents relinquish custody to the State. Children who are in the custody of the State have a right to family involvement that is safe and appropriate.

7. All children and adolescents, regardless of parental involvement, should have access to all core services and supports within their local community.

8. The system of care functions best when there is coordinated administrative and financial planning, and collaborative service delivery among all involved parties. Families and the general public must be well informed about available options and procedures for using the system of care.

9. Children, adolescents, and their families should be assured smooth transition into and through the system of care, including transition into adult life.

10. The rights of children, adolescents, and their families should be protected. Effective advocacy efforts and assistance in becoming their own advocates should be promoted for all children, adolescents, and their families.

11. Children, adolescents, and their families should receive services without regard to their race, religion, national origin, gender, sexual orientation, disability, or socio-economic status. Service policies and practices should be sensitive and responsive to cultural differences and special needs.

12. Services and supports are best provided by people who are competent, well trained, and well supported.

13. The system of care must be based upon the latest research available and ongoing evaluation about what is effective. Program evaluation should incorporate information from program recipients as well as service providers.

SECTION II:

THE REALITY:

WHERE WE ARE

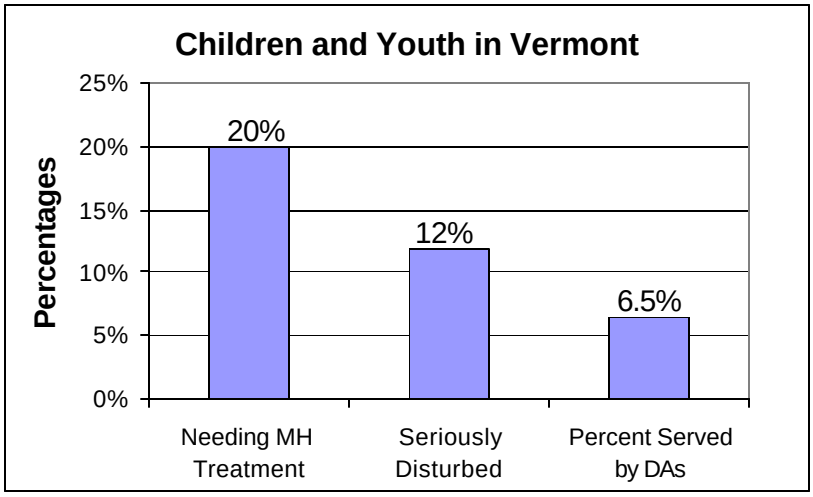
ESTIMATES OF PREVALENCE OF NEED

"Approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV [mental health] disorder during the course of a year," according to the United States Surgeon General (1999).[2]

The number of people aged birth to 18 in Vermont is approximately 139,594.[3] Thus, about 28,000 (one in five, or 20%) children and youth in Vermont may be in need of mental health treatment each year.

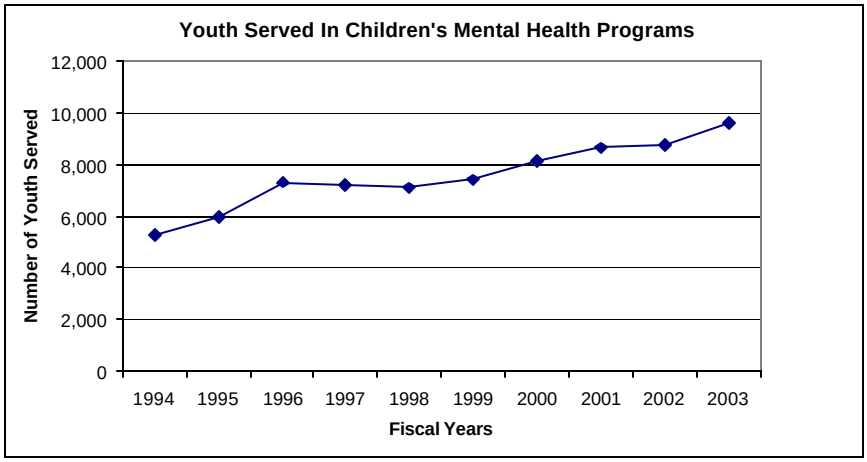
The federal Center for Mental Health Services estimates that close to 17,000 (about 12%) of Vermont's children and youth may be experiencing serious or severe emotional disturbance each year.[4]

Figure 1



The percentage of children and youth aged 0-18 in Vermont who received public children's mental health services increased from 4.3% to 6.5% over the past five years.

Figure 2



In 2003, Vermont's public children's mental health programs served 9,581 people. The remainder of the 17,000-28,000 children and youth estimated to be in need of mental health treatment in Vermont may or may not have received service from private providers.

DESCRIPTION OF THE POPULATION IN NEED

Research indicates that many factors contribute to a child's need for mental health treatment. These factors tend to come from the child's environment and/or from the child's biological make-up.[5]

Factors from the child's environment may include:

> …physical, sexual or emotional abuse; physical trauma; domestic violence and substance abuse in the family system; severe neglect; malnutrition, ill health, lack of caring adults; numerous transitions; unsafe or unsanitary living conditions; exposure to familial violence; harsh or inconsistent discipline; having one or two parents with a psychiatric disability. *(ibid)*

Factors from the child's biological make-up may include:

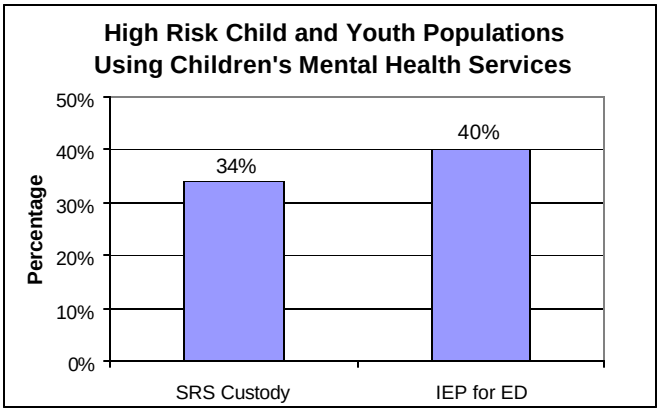
> …genetic, neurological and biochemical factors such as family history of depression, learning difficulties (especially reading), impulsivity and temperament. These elements can contribute causative factors to a severe emotional disturbance. In some situations medical conditions such as allergies, asthma, traumatic brain injury, seizure disorders, *etc.* can be the direct cause of emotional or behavioral difficulties…. Additionally,… exposure to toxins (environmental, chemical and nutritional)…. *(ibid)*

These risk factors – many of which are related to living in poverty – can be somewhat lessened and/or prevented by prenatal and perinatal medical care, childhood immunizations, home visiting and other forms of parenting support and training, high quality early care and education (especially to foster reading readiness, self-control, and social skills), and success in school. *(ibid).* Public children's mental health services can offer parenting support and training and can help children learn self-control and social skills.

Because of the presence of significant risk factors in their lives, children from three special populations receive mental health treatment in higher proportions than the proportion of children in the general or overall population (shown in Figure 1 above) who receive treatment. These special populations of children are those who are:

1. enrolled in Medicaid due to poverty and/or disability,
2. in the custody of the State Department of Social and Rehabilitation Services (SRS) due to abuse, neglect and/or delinquency, and/or
3. on an Individualized Education Plan (IEP) in school due to an emotional disability (ED).[6]

Figure 3



DESCRIPTION OF THE CHILDREN AND FAMILIES SERVED

Vermont's public mental health system for children primarily – but not exclusively – serves children and families who are enrolled in Medicaid. In 2003, at least 64% of the 9,581 children and youth served were enrolled in Medicaid. Some families have private insurance or other sources of health coverage in addition to Medicaid.[7]

Responsibility for Fee	Medicaid	Medicare	Other Insurance	State Agency	Unknown
% of Children Served	64%	0%	22%	3%	23%

In 2003, 48% of the children served were teens aged 13-19.[8] Use of children's mental health programs by teenagers declined while use by younger children increased substantially, especially for children aged 0-5. The significant increase for this young population may be due in part to the Children's UPstream Services or CUPS initiative, which increased the system's ability to address the needs of Vermont's youngest children.

In 2003, 58% of the children served were boys.[10] Use of children's mental health services by boys increased more than the use by girls (17% vs. 11%) from 1999 - 2002.[11]

For the purpose of effective treatment planning, children and youth are assessed when seen by children's mental health workers and are then assigned one or more diagnoses. In 2003, children served had diagnoses that included adjustment disorder, anxiety disorder, affective disorder, substance abuse disorder, and schizophrenia/psychosis among others.

One way to illustrate what these diagnoses can mean in the lives of families is to tell stories. We have included four stories in Appendix A, which present composites of fairly common conditions and experiences of the children served. To assure confidentiality and protect privacy, none of the stories are about any one known person. However, they illustrate the diversity of diagnoses, severity of symptoms, and range of treatment options, as well as the complexity of situations faced when trying to meet the needs of children and adolescents experiencing mental health problems and their families. [See page 31 for stories about Devon, Amy, Cathy, and Sam.]

What We Do

DESCRIPTION OF ORGANIZATIONAL STRUCTURE

In Vermont, mental health services are delivered by ten independent, private, non-profit community mental health centers, also known as "designated agencies." These centers receive funding and oversight from the State Department of Developmental and Mental Health Services (DDMHS). The Department is one of several under the administration of the Vermont State Agency of Human Services (AHS) (Figure 4).

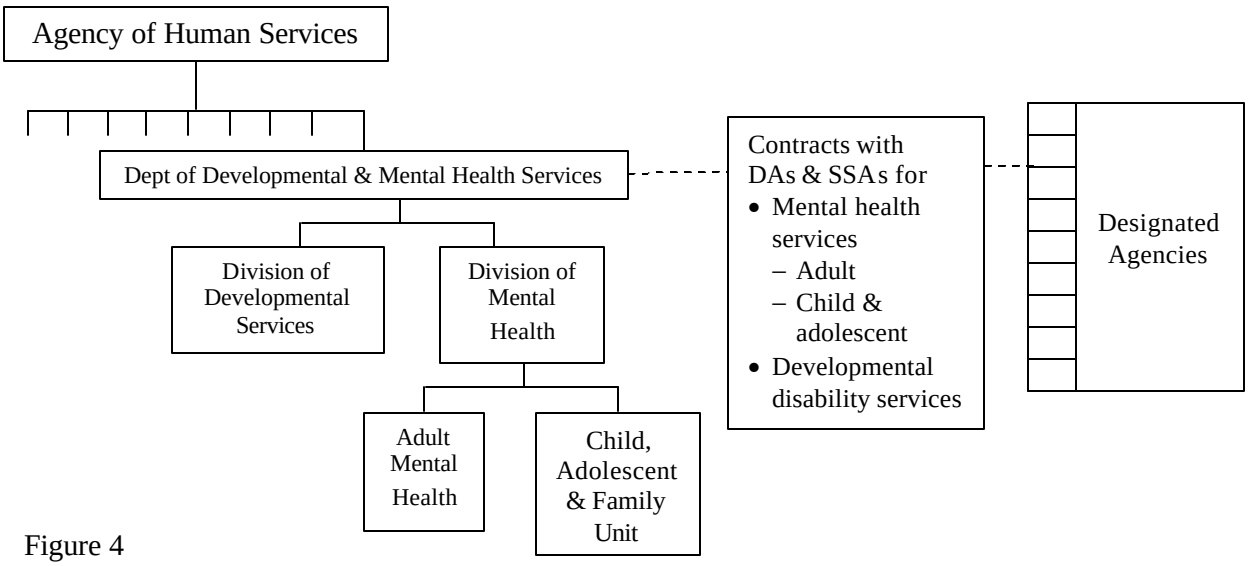


Figure 4

The Child, Adolescent and Family Unit (CAFU) is part of the Division of Mental Health (DMH) within DDMHS. The CAFU is charged by Vermont's Act 264 with serving children with severe emotional disturbance. Other units and divisions within the DDMHS serve adults with serious and persistent mental illness and people with developmental disabilities. CAFU is committed to ensuring the delivery of a comprehensive array of effective mental health supports and services for children and families statewide.

Children's mental health services and supports are delivered through a system of designated agencies (DA). Statewide, there are ten community mental health centers designated by the Commissioner of DDMHS as meeting state and federal laws, regulations, and quality standards for the provision of community mental health services for children. Each DA is responsible for providing specified core public mental health services in a given region (see map of catchment areas in Appendix C, manual page 39). The one specialized service agency (SSA) provides very intensive services to youth from anywhere in the state.

Together, the Division of Mental Health's Child, Adolescent and Family Unit and the designated agenices are dedicated to expanding and improving the core capacity services offered throughout Vermont. A team of professionals, paraprofessionals, and community volunteers provide or arrange the following services, with the intensity and duration determined by family/individual need.

CORE CAPACITY SERVICES AVAILABLE REGIONALLY THROUGH DESIGNATED AGENCIES

1. *Immediate Response*:

Each DA provides access to an immediate response service and/or short-term intervention for children and adolescents who are experiencing a crisis and their families. Crisis services are intensive, time-limited (usually 2-3 days) supports consisting of the following elements:

- Telephone assessment, support and referral
- Crisis assessment, outreach and stabilization
- Family and individual education, consultation and training
- Service planning and coordination
- Emergency/crisis bed
- Screening for inpatient psychiatric hospitalization

2. *Outreach Treatment*:

Each DA offers a comprehensive array of outreach treatment services for children and families. These services employ best practice in outreach clinical service delivery and are available in the home, school and general community settings. The intensity of the service is based on the clinical needs of the child and family and the family's request for one or more of the following elements:

- Clinical assessment
- Group, individual and family therapies
- Service planning and coordination (including residential case review)
- Intensive in-home and out-of-home community services to child and family (including foster and adoptive families)
- Medication services
- Family and individual education, consultation and training

3. *Clinic-Based Treatment*:

Each DA offers a comprehensive array of clinic-based treatment services for children and families. These services employ best practice in office-based clinical service delivery and are available during daytime and evening hours when families can easily access them. The intensity of the service is based on the clinical needs of the child and family and the family's request for one or more of the following elements:

- Clinical assessment
- Group, individual, and family therapies
- Service planning and coordination
- Medication services

4. *Support*:

Support services can be instrumental in reducing family stress and providing parents and caregivers with the guidance, support and skills to nurture a difficult-to-care-for child. Each designated agency provides and/or has direct community connections to a comprehensive array of support services for families and youth. These services are offered in partnership with parents, and consumer advocates, and are provided as the family needs and desires:

- skills training and social support
- peer support and advocacy
- respite
- family and individual education, consultation and training

5. *Prevention, Screening, Referral and Community Consultation:*

Each designated agency provides and/or has direct involvement in creating and/or maintaining community agreements that promote psychological health and resilience for families and youth. Primary prevention efforts focus on promoting healthy lifestyles and healthy communities for all youth and families. Secondary prevention efforts focus on reducing the effects of risk factors, minimizing trauma potential, and maximizing resiliency potential. Tertiary prevention (i.*e.*, treatment) efforts focus on reducing any trauma and dysfunction that may be created by a difficult event or situation. The prevention agreements may focus on one or more of the following elements:

- work with families, community groups, schools and health and child care providers to improve situations/environments for children and families and to provide education, consultation and training;
- screening and referral; and
- educational activities about mental health for the public at large.

INTENSIVE SERVICES AVAILABLE STATEWIDE

In addition to core capacity services provided by designated agencies for each region, there are intensive residential services, emergency/hospital diversion beds, and hospital inpatient services available to the entire state of Vermont.

1. ***Intensive Residential Services:***

   DDMHS contracts with three residential treatment programs to provide intensive mental health residential treatment for children and youth in Vermont: The Baird Center for Children and Families (a division of the Howard Center for Human Services), Northeastern Family Institute (NFI), and Retreat Healthcare. These programs have around-the-clock awake staff, medical/psychiatric backup services, and an in-house array of psychological assessment and treatment services.

2. ***Emergency/Hospital Diversion Beds:***

   Emergency or hospital diversion beds are community-based programs that provide a very high level of care and have the ability to divert youth from in-patient hospitalization. Typically, youth who do not require around-the-clock medical monitoring can be stabilized in a smaller, less institutional treatment setting. Like the Intensive Residential Services, Hospital Diversion programs have 24-hour awake night staff, 24-hour psychiatric and in-house crisis back up, and the ability to conduct psychological, neurological and other specialized testing as needed. The typical length of stay in these services is one to ten days.

3. ***Hospital In-patient Services:***

   In-patient hospitalization may be required for youth with a mental illness who:

   - require around-the-clock medical monitoring for such things as drug overdoses, suicide attempts or other complicating medical conditions;
   - have complex and uncontrollable behaviors such as causing or threatening harm to themselves and/or others;
   - cannot be stabilized in a smaller and more individualized hospital diversion treatment setting; and/or
   - meet the criteria for an emergency exam (EE).

   Three hospitals provide psychiatric in-patient services for Vermont youth: Champlain Valley Psychiatric Hospital in Plattsburgh, New York; Cheshire Medical Center in Keene, New Hampshire; and Retreat Healthcare in Brattleboro, Vermont. A child meeting the criteria for an emergency exam may be placed only at Retreat Healthcare.

Who We Are

DESCRIPTION OF STAFF

In calendar year 2003, according to the DDMHS management information system, eight of the ten DAs reported employing a total of 949 full-time, part-time and contractual workers in their children's mental health programs. Of these 949 staff: 76% were female, and 24% were male. (Clerical, maintenance, and medical personnel (*e.g.*, doctors and nurses) of the agencies are not counted here.)

At least 653 individual staff filled 484 full-time equivalent (FTE) clinical positions such as program director (13 FTE), program coordinator (50 FTE), clinician (260 FTE), or case manager (161 FTE). The average salary for these clinical workers in 2003 was $18.33 per hour. Nearly half (47%) of the clinical staff had a Master's Degree or a Doctorate (M.D. or Ph.D.).

At least 296 individual staff filled 126 full-time equivalent other positions such as contracted day/respite worker (11 FTE), community integration specialist/support worker (107 FTE), home/residential support worker (8 FTE), or other positions. The average salary for these other staff was $15.41 per hour. Nearly three-quarters (73%) of the other staff had a Bachelor's or Master's Degree.

Certain attitudes, knowledge and skills are expected of the staff who directly serve children and youth who are experiencing severe emotional disturbance. These competencies were identified by DDMHS with extensive input from children's mental health staff. These competencies for children's mental health services staff are as follows.

1. Demonstrates respect for children and youth experiencing severe emotional disturbance, their families, community, and culture, and builds and maintains positive relationships with individual children, youth, and their families.
2. Demonstrates an understanding of the principles of collaborative, community-based care.
3. Demonstrates current knowledge of human development, severe emotional disturbance, and behavior disorders.
4. Knows and uses best practices of assessment and screening.
5. Knows and uses best practices of intervention and support strategies for children, adolescents and their families.
6. Designs, delivers, and documents highly individualized services and supports.
7. Conducts activities in a culturally competent manner.
8. Effectively accesses and employs community resources.
9. Works in a cooperative and collaborative manner with all stakeholders and works as a team member within and across service systems.
10. Demonstrates knowledge of legal issues and civil rights that are relevant to work setting and occupation.

11. Knows best practices of systems change, advocacy and prevention.
12. Develops basic management skills.
13. Conducts activities in a professional and ethical manner.
14. Knows methods of evaluation and applies them appropriately to own work.

The degree to which the children's mental health staff of the DAs display these kinds of competencies is measured by regularly-scheduled DDMHS satisfaction surveys of youth, parents, and key stakeholders who interact with the agency staff.

Given the education and competencies expected of children's mental health workers, their salaries are low. This contributes to a high level of staff turnover. Of the 975 FTE children's mental health workers in calendar 2002, 29% had been hired within the previous year, with another 33% hired within the past two years. Since building therapeutic relationships is at the heart of much mental health treatment, staff turnover is a critical challenge for assuring quality of care. The Vermont Association for Mental Health (VAMH) "2003 Social Policy Priorities" says:

> The issue of adequate salary compensation for staff in our public system cannot be ignored or neglected. Adequate compensation for our workforce is not simply about money. It relates directly to the quality of care provided within our public behavioral health care system.[14]

A subsequent VAMH paper reiterates that "High staff turnover rates are symptomatic of an overworked and underpaid workforce."[15]

DESCRIPTION OF RESOURCES

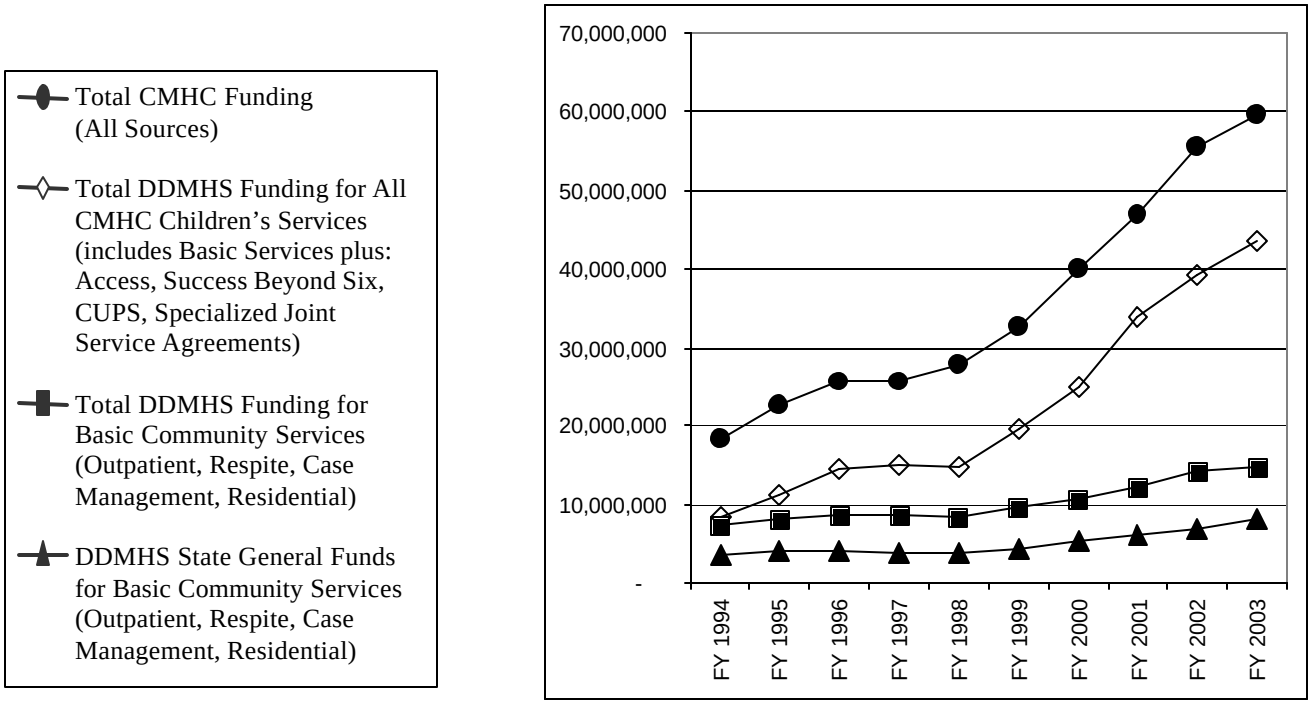
Ideally, a child's treatment plan includes full use of the family, friends and community supports that are naturally available to that child and family. Examples might include mentoring by neighbors and participation in sports teams or church youth group activities. When informal supports are not sufficient to meet a child's needs for supervision and/or care, the use of other resources such as formal services may be required.

The greatest resource available from the children's mental health system is the time of staff. Staff time is paid for by revenues from various sources including federal Medicaid and its related State General Funds, private insurance, state and federal grants, and local or other sources. "Between 1999 and 2002, Medicaid increased from 60% to 73% of all revenues to children's services programs….Overall funding of children's service programs increased by more than 20% per year during this [time]…from $30,032,687 to $50,283,729."[16]

However, as shown in the graph about Children's Mental Health Funding (Figure 5), there has been very little increase in the General Fund appropriation for child and adolescent mental health since 1994. Children's mental health programs have been resourceful and creative in finding other funding sources for the growing caseload of Vermont children identified as needing services; this explains the overall growth in funding for mental health services in the chart. Two examples are (1) successfully competing for major service grants from federal and private foundation sources, and (2) asking other State department partners to contribute some of their General Fund allotment to Mental Health in order to draw down federal Medicaid funds to pay for services (*e.g.*, Education, SRS, Health).

Children's Mental Health Funding

Figure 5



What's Working or Not

QUALITY ASSURANCE AND IMPROVEMENT

DDMHS believes it is important to assure ourselves, consumers, and the public that our system of care provides a high level of quality, and to work in partnership to continually improve our system of care. The Department has developed two processes to systematically accomplish these goals.

The first process is called *Agency Designation*. At least once every four years, a team of department staff and members from the Governor-appointed State Program Standing Committee conduct a comprehensive review of each designated agency to assure quality performance across a wide range of criteria. As a result of this process, an agency can be rated as (a) doing well, (b) needing some improvement that is detailed in a corrective action plan, or (c) failing to meet the standards and, as a result, being cut from the contractor network.

For the second process, every two years a team of CAFU staff and members from the State Program Standing Committee conduct a *Program Review*. The focus is to gather detailed data on four quality domains: access to care; practice patterns of care; results of care; and agency structure/administration. The findings of this intensive review form the basis for on-going discussions and planning for program development, resource allocation, and budgeting.

As part of these two Department processes to assure and continually improve quality, CAFU has developed two sets of data specific to child/adolescent mental health: (1) measures caseload integration, and (2) a 4-year cycle of satisfaction surveys. Because of the risk factors in their lives, many children served by mental health also receive other services, especially from SRS and Special Education. Children's mental health, SRS, and Special Education must put extra effort into the service integration required to work together well to meet the complex needs of the children they serve in common. One way to evaluate this service integration is to measure caseload sharing; another is to measure satisfaction with services. Both measures are discussed below.

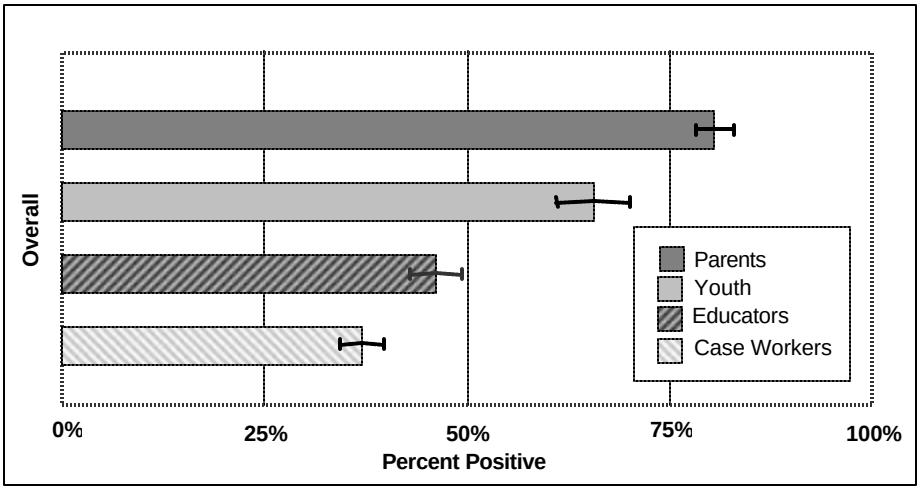
Caseload integration consists of those "cases" or situations in which children served are on the caseloads of more than one program at the same time. For instance, a child may be on the caseloads of both children's mental health and SRS, or of SRS and Special Education, or of children's mental health and Special Education, or on the caseloads of all three programs at the same time. On a scale from 0-100, from no caseload sharing (0) to complete caseload sharing (100) between children's mental health and SRS and Special Education, "Vermont has experienced a fairly consistent trend toward increased caseload integration since 1993, when the caseload integration ratio was 21, through 2003 when the caseload integration ratio was 33."[17]

Given this level of caseload integration, both *SRS social workers* and *educators* are considered key stakeholders for measurement of satisfaction with children's mental health services. The other key stakeholders are *youth* and their *parents.* All four sets of stakeholders have received written surveys from the DDMHS asking about their satisfaction with children's mental health services: Medicaid-eligible youth aged 14 to 18 were surveyed in 1999, SRS workers in 2000, educators in 2001, and parents in 2002. The cycle began again with youth in 2003. As far as possible, the respondents in each stakeholder group are asked the same questions.

"Statewide, there are considerable differences in level of scores on each scale between stakeholder groups. The two consumer stakeholder groups gave the highest evaluations, with parents (81%) being the most positive *Overall,* followed by the youth (66%). The professional groups gave considerably lower evaluations, with educators (46%) being more positive *Overall* than SRS workers (37%)."[18]

Statewide Multi-Stakeholder Comparative Positive Evaluation of Child & Adolescent Mental Health Programs

Figure 6



The type of information gathered is both objective (*e.g.,* caseload integration ratio, number of youth served) and subjective (*e.g.,* different stakeholders' perceptions of degrees of satisfaction) as well as broad in scope (*e.g.,* from agency's financial viability to degree of consumer and family involvement). By measuring the same elements in cycles, state and local people together can protect components that work well, focus on specific items that need improvement, and measure progress over time.

CAFU PLANNING PROCESS

The Department and its designated agencies engage in on-going planning processes to improve and maintain services for children's mental health: annual budgeting, annual revisions to three-year local and state System of Care plans (including this document), ongoing Program and Agency Designation Reviews, special topic task forces, interagency planning (*e.g.*, for the Act 264 *Vermont System of Care Plan for Children and Adolescents with a Severe Emotional Disturbance and Their Families*), and systematically fostering the use of current clinical best practices through technical assistance and training. All of these processes lead to the identification of:

(A) strengths and accomplishments,

(B) significant unmet needs, and

(C) results of planning process: priorities for action --- next steps.

These are discussed below according to the desired outcomes for the four domains of quality service: access to care, practice patterns, outcomes, and administration.

(A) STRENGTHS AND ACCOMPLISHMENTS

Quality Domain #1	Desired Outcome
Access to Care	***The five Core Capacity Services are available to children and families in need***

More children have been served. Designated agencies increased the number of children and adolescents served from 5,304 in FY1994 to 9,581 in FY2003.

Core Capacity: Clinic Treatment:

Although it is very difficult to find child and adolescent psychiatrists nationally and in Vermont, it is even more difficult to attract them to public mental health given salary levels. Nevertheless, the need for their services is growing and Vermont's 10 designated agencies have increased their capacity. At the start of 2004, the system had increased its capacity to 6 FTE child and adolescent psychiatrists and 3 FTE psychiatric nurse practitioners.

Core Capacities: Outreach Treatment:

Although clinic-based services continue to meet an important treatment need, many children and families benefit from the easier access to care made possible by a wide range of outreach treatment services through schools, child care centers, and doctors' offices. A clear example is development of the children's mental health Success Beyond Six funding initiative. During the five years from FY1998 to FY2002, Success Beyond Six grew from 120 to 470 FTE mental health workers located in the schools. In FY2003, DAs served 4,578 children through Success Beyond Six funding. This equals 47% of the 9,581 children ages 0-20 served by children's service programs through DAs. The schools' investment in these services grew from approximately $1.8 to $6 million. Success Beyond Six began in 1994 with community mental health centers offering schools services such as home-school coordination and psychotherapy for children and families. It now supports over a dozen regional and specialized alternative education and treatment programs, including programs for children with progressive developmental disorders such as autism.

Core Capacities: Family Support and Prevention Services:

In State FY1998 the Children's UPstream Services (CUPS) grant began. Through FY2003, CUPS provided service directly to the families of 2,300 children aged 0-6, and/or teen parents, who are experiencing serious emotional disturbance.

Quality Domain #2	Desired Outcome
Practice Patterns of Care	***Services provided are appropriate, of high quality, and reflect current best practices.***

All of Vermont's public mental health agencies have been reviewed and awarded the status of designated agency.

All designated agencies and specialized service agencies now have quality improvement plans that include feedback from client families.

Several designated agencies have applied for and received accreditation from national organizations such as CARF and JAHCO.

Core Capacities: Family Support and Prevention Services:

From the start of CUPS through the end of FY2003, the 20 FTE grant-funded mental health workers and others funded by Medicaid delivered more than 6,800 consultations to child care and other programs. They also delivered over 1,000 cross-training events for parents and other early care, health and education providers on topics related to child development, behavior management, mental health treatment, *etc.*

Quality Domain #3	Desired Outcome
Results of Care	***The quality of life improves for children and families served.***

Children's mental health services directly benefit children and adolescents by helping them to successfully develop and remain in their own families, schools, and communities. Indirectly, children's mental health services also benefit other partners in the system of care.

Core Capacities: Family Support and Prevention Services:

1. An independent evaluation of parents and children served by CUPS shows reduced stress, improved behavior, and satisfaction with services.
2. A study of the children's mental health respite program showed that families were very satisfied with the respite they received.[19] A subsequent controlled longitudinal study of the short-term effectiveness of this program indicated that 33 families caring for a child with an emotional disability who received respite care experienced significantly better outcomes overall than did 28 families in a wait-list comparison group, including fewer incidents of out-of-home placements, greater optimism about caring for the child at home, reductions in some areas of care-giving stress, and lower incidence of negative behaviors expressed in the community.[20]

Core Capacity: Immediate Response:

1. The number of children admitted to State custody declined substantially after the implementation of "Families First" (formerly called the Access Vermont/Family Preservation Initiative), which began during FY1995. Most importantly, through FY2002, there has been a 40% reduction in the number of admissions to State custody of unmanageable youth under age 16 (from 235 in FY1995 to 142 in FY2003) and a 44% reduction in Social and Rehabilitation Services' average daily population of unmanageable youth of all ages (from 425 in FY1995 to 239 in FY2003). This population of children with serious emotional disturbance is the primary target for "Families First" services.
2. In partnership with the Office of Vermont Health Access (OVHA), the DMH has since FY2000 managed the utilization of public psychiatric hospital beds in Vermont. In FY2001 this effort was expanded to include children's mental health. Child and adolescent hospitalization was significantly reduced from FY2000 to FY2003. The number of bed-days was reduced by 35%, the cost was reduced by nearly 10%, and children were returned safely to their homes and communities. Sufficient funds were saved to pay for the creation in FY2002 of emergency beds in southern Vermont. In FY2003 these beds further reduced the need for admission to psychiatric hospitals for some children and adolescents experiencing serious emotional disturbance.

Quality Domain #4	Desired Outcome
Administration	***Agencies will be fully functional and have strong working relationships with DDMHS, families and other stakeholders.***

All DAs have enhanced the voice of families by creating Local Program Standing Committees composed of family representatives and key stakeholders to advise each program. Each committee must have a minimum of 51% consumers/family members to assure that DAs hear what families know and need.

(B) SIGNIFICANT UNMET NEEDS

Quality Domain #1	Desired Outcome
Access to Care	***The five Core Capacity Services are available to children and families in need***

The U.S. Surgeon General's report on mental health estimates that 12% of children and youth in Vermont have a severe or serious emotional disturbance. In FY2003 only 6.5% of Vermont's children and youth received public mental health services. While an unknown number of the remaining 5.5% of Vermont's youth with a severe need received clinic based services from private sector mental health providers, there is clearly a significant unmet need for more treatment capacity for children and their families, as well as for consultation with teachers, child care providers, and other direct service (including health care) workers. It now seems technically feasible to determine how many children are being served in the private mental health sector and, therefore, possible to calculate how many more Vermont youth might still need public sector treatment services and supports. The following core capacities for treatment and support must be expanded with additional resources and staff for the mental health centers.

Core Capacity: Outreach Treatment:

An effective public mental health approach to serving more children, youth and families is to reach out to them in the community in schools, child care centers and day care homes, and pediatric offices. The CAFU is exploring how to help fund some outreach services through a specific type of Medicaid funds available for Early, Periodic Screening, Diagnosis and Treatment (EPSDT). A major limitation on the use of Medicaid is the availability of State General Funds for match.

Core Capacity: Clinic Treatment:

Most of the DAs report waiting lists for psychiatric services and difficulties in contracting with psychiatrists. The Department has been exploring the possibility of multiple agencies in a community jointly purchasing psychiatric (1) supervision for designated agency clinical staff and (2) consultation with pediatricians. In addition, some designated agencies have been able to hire psychiatric nurse practitioners. Collectively the designated agencies have 6 FTE psychiatrists and 3 FTE nurse practitioners. The wait for a psychiatric evaluation ranges from 1 week to 6 months, with an average wait across agencies of 10 weeks.

Not all youth and their families who are entitled to an *Act 264 Coordinated Service Plan* and would benefit from one are aware of their right to have one. This plan can open doors to other services and supports beyond mental health that could help the child and family achieve their goals. Informing the family of this possibility is a function of agency staff, but, due to high rates of staff turnover in agencies around the state (including lower rates of staff turnover in child welfare and education), not all staff are prepared to educate the family about this avenue to services. We need more on-going interagency training of staff and routine methods to inform families.

Quality Domain #2	Desired Outcome
Practice Patterns of Care	***Services provided are appropriate, of high quality, and reflect current best practices.***

In part because DAs experience over 20% turnover among their children's mental health staff every year, there is an ongoing need for in-service training of staff, particularly in the following areas.

Core Capacity: Immediate Response:

The staff who respond to mental health emergencies should be trained to respond to child and family crises in ways that support the child and family and the community.

Core Capacity: Outreach Treatment:

1. More staff should know how to design and deliver individualized services and supports in the community, especially for children with intensive needs. Only 229 (2%) of the 9,581 children and youth served in FY2003 received intensive services in accordance with Individualized Service Plans and budgets or Waivers. Far more children and youth need these services, including:

   - those with Pervasive Developmental Disorder who have an IQ over 70;
   - those who have been repeatedly ejected from day care programs;
   - those whose adoptions are at risk of failing;
   - those with co-occurring substance abuse;
   - those in transition to adult services.

   As with other services, the limitation on intensive services is the availability of State General Funds needed for the Medicaid match. Although additional State General Funds were appropriated for match for intensive services in FY2001 ($400,000) and again in FY2003 ($250,000), the need far exceeds the resources.

2. There are increasing numbers of adolescents experiencing severe emotional disturbance who also use alcohol or drugs. More staff in designated agencies should be trained in screening and prevention strategies for such use and in effective and integrated treatment methods.

Quality Domain #3	Desired Outcome
Results of Care	***The quality of life improves for children and families served.***

The state now has data on several of its desired outcomes, but not all. We have increased our ability to share data across agencies about numbers (not names) of youth and their performance on "bottom line" outcomes such as numbers graduating from high school. However, the field of mental health is still developing agreed upon methods and tools for measuring more immediate indicators of improvement in areas such as daily life.

Core Capacity: Outreach Treatment:

National data (Clark and Deschenes, 2002) indicate that transition-aged youth with serious emotional disturbance drop out of school and are later incarcerated at much higher rates than their peers without this disability.[21] The Vermont JOBS (Jump On Board for Success) program has a very successful record of improving the outcomes for these youth. Their data show that youth who complete the program have reduced their relapse rates with substance abuse and corrections and boosted their level of educational achievement and their rate of employment. JOBS is a supported employment and therapeutic case management program collaboratively funded by the State Divisions of Vocational Rehabilitation, Mental Health, and Social Services, and by the Department of Corrections. However, it is only available to youth in 7 of 10 mental health regions of Vermont. There are no JOBS programs in the Orange/North Windsor, Southern Windsor and Windham regions. The lack of JOBS programs for youth in these regions leaves them vulnerable to poor outcomes.

Quality Domain #4	Desired Outcome
Administration	***Agencies will be fully functional and have strong working relationships with the department, families and other stakeholders.***

Continuing to increase low staff salaries will help with the hiring and retention of qualified, experienced staff. The increasing difficulties in hiring and retaining skilled staff are more than an expensive and time-consuming challenge for a designated agency. They also create a serious challenge for families trying to access services if there are staff vacancies, for families trying to build a trusting and productive therapeutic relationship with staff who may change several times, and for families and staff trying to keep moving toward positive outcomes.

Continuing to increase the level of family involvement in department and designated agency program development and treatment planning will contribute to improved quality in all of the four domains of quality service.

(C) RESULTS OF PLANNING PROCESS

In order to arrive at state-level priorities for action for FY2005-2007, the Child, Adolescent, and Family Unit has reviewed the following information:

- recommendations from the designated agencies' local system of care plans, submitted annually in February,
- recommendations of the Act 264 Advisory Board submitted annually in January (see Appendix A),
- findings from on-going site visits for designated agency Program and Designation Reviews,
- results of the CAFU's ongoing satisfaction surveys,
- Department data on services and costs, and
- recommendations from the children's mental health State Program Standing Committee.

See *Section III* for the resulting priorities and anticipated next steps for improving Vermont's mental health system of care for children and adolescents and their families.

SECTION III:

THREE-YEAR PRIORITIES:

HOW TO GET FROM WHERE WE ARE TO WHERE WE WANT TO GO

NEXT STEPS: GOALS, ACTIONS NEEDED, AND MEASURES OF PROGRESS

State Level Child, Adolescent & Family Mental Health

Priority Needs	Current Status	Goals for Fiscal Year 2005 to 2007	Action Needed	Measures of Progress
Access to Care				
Serve more youth in need.	Vermont's public mental health system currently serves 6.5% of our youth annually while the U.S. Surgeon General's report on mental health estimates 12% of our youth need such services.	• Determine how many of the remaining 5.5% of Vermont youth needing services receive them through the private mental health system. • Find additional funding.	• Work with private insurers and practitioners to determine how many youth they serve. • Apply for appropriate grant funds. • Explore the use of EPSDT Medicaid funds. • Legislative advocacy for increased funding.	• Learn the number and % of youth served by the private mental health system. • Calculate the % of youth not being served by either the public or the private mental health systems. • Secure grant funding. • Expand the use of EPSDT Medicaid funds if possible. • Secure additional funding for services from the legislature.
Assure consistent use of Coordinated Service Plans for eligible youth.	Due to high rates of staff turnover in agencies around the state, not all staff in DAs, SRS, and schools are aware of the entitlement to such a plan for some youth and the resources of the interagency system of care.	• All direct service staff in DAs will be trained in when and how to write a CSP.	• Develop and maintain on-going training mechanisms. • Develop capacity to track CSPs written and their outcomes.	• Track number of CSPs written for children and adolescents. • Track number of training events and number of staff attending. • Staff surveyed report they understand CSPs and write them as appropriate.

Priority Needs	Current Status	Goals for Fiscal Year 2005 to 2007	Action Needed	Measures of Progress
Practice Patterns in Care: ***Immediate Response***				
Emergency services reflect a statewide level of quality for children and adolescents.	Emergency response is available 24 hours/day, 7 days/week statewide. There remains variation around the state with outreach capacity; the expertise of emergency staff with children and adolescents; follow-up connections with DA staff, community resources, and families; and a community's ability to distinguish between and respond to different types of crises (*e.g.*, mental health crisis, placement crisis).	• Higher level of training of mental health emergency response teams for children and adolescents. • All regions of the state have mobile outreach capacity. • Minimize removal of children from home during a mental health crisis. • Stakeholders in all regions continue to develop resources to meet different types of crises in the lives of children, adolescents, and their families.	• Increase training for emergency service teams. • Increase crisis stabilization abilities in home and community settings. • Continue public education about the different types of crises and public planning to address them.	• Mobile outreach emergency services are delivered in all regions. • Increased levels of emergency services provided in home and community settings. • C/F and stakeholders report higher levels of satisfaction with emergency service response. • Decrease in numbers of repeat placements in hospitals and hospital diversion programs. • DA staff report existence of community services for different types of crises.
Practice Patterns in Care: ***Outreach Services***				
Further develop access to integrated substance abuse treatment for adolescents.	Increasing need for substance abuse treatment for adolescents with mental health issues.	• Determine the need thru use of common assessment tool. • Determine best practices. • Develop mechanisms to provide treatment.	• Work with the Alcohol and Drug Abuse Programs (ADAP) and other service providers to jointly fund individualized plans for youth with intensive needs.	• All youth screened at intake. • Increase number of youth served. • Decrease number of youth reporting use of alcohol and drugs.
Increase use of individualized plans for youth with intensive needs.	200 youth receive such plans in an average year. More youth with intensive needs could benefit from this approach.	• Increase the number of youth served through individualized plans for meeting intensive needs by decreasing use of residential days. • Further develop capacity in all regions of the state.	• Increase training of DA staff for youth with intensive needs.	• Increased number of children and families served through community-based individualized plans. • Further develop and use methods to chart benefit of this approach for youth with intensive needs.

Priority Needs	Current Status	Goals for Fiscal Year 2005 to 2007	Action Needed	Measures of Progress
Practice Patterns in Care: ***Clinic Based Services***				
Continue to develop child and adolescent psychiatric services.	Long wait in many regions due to scarcity of child psychiatrists and funding levels.	• Develop capacity for child psychiatric consultation to pediatricians and family doctors.	• Develop the consultation model, including work with psychiatric nurse practitioners.	• Reduced waiting time.
Practice Patterns in Care: ***Support Services***				
Increase respite capacity.	$765,000 in general fund serves approximately 50% of the reported need.	• Increase the number of youth and families with respite. • Strengthen families' connections in their community to related providers and groups.	• Increase use of natural supports for respite. • Encourage use of quality community programs for child care, after school, and summer in integrated settings. • Recruit and train additional respite workers.	• Increased number of units of respite provided. • Increased number of youth and families served. • Decrease in length of time specific families utilize DA's respite services.
Practice Patterns in Care: ***Prevention, Screening, Referral, and Community Consultation***				
Increase availability of information promoting good mental health and explaining treatment options for children and families.	Many families and stakeholders do not understand how mental health affects children and their families and do not know what treatment options are available thru DAs.	• Increase public awareness of services provided by DAs. • Continue work to reduce stigma associated with mental health issues and treatment. • Foster a public health model for mental health. • Explore all possible sources of services and service configurations.	• Foster public education about mental health at all levels of the system of care, especially strategies to promote wellness. • Focus education efforts about services offered by DAs on key stakeholder groups (*e.g.*, SRS, education, pediatricians). • Create or maintain and publicize regional resource guides about services and out-patient providers. • Expand connections with private therapists who take Medicaid and are knowledgeable about outreach services available thru DAs and the interagency system of care.	• Variety of public marketing methods used by CAFU and DAs. • Number of presentations made to key stakeholder groups. • Increased number of families and stake-holders report that they are aware of services offered by DAs. • 10 regional resource guides. • Increased number of youth served.

Priority Needs	Current Status	Goals for Fiscal Year 2005 to 2007	Action Needed	Measures of Progress
Practice Patterns in Care: ***Prevention, Screening, Referral, and Community Consultation***				
Maintain services for children aged 0-6 and their caregivers.	CUPS migrated to Department of Child and Family Services in 2004.	• Maintain CUPS direct services and consultation for children, families, and child care providers.	• Organize orderly transition during AHS reorganization to new Department of Child and Family Services.	• Number of children and families served. • Number of child care providers served.
Results of Care				
Develop more comprehensive outcome measurements.	The state level has outcome data on several of its desired outcomes, but not all. DAs vary widely in their ability to collect, analyze, and use their outcome data to improve the effectiveness and efficiency of their services and the satisfaction of their consumers and stakeholders.	• Increase focused work with CAFU, DAs, C/F, and stakeholders to collect, analyze, and use data to improve the system of care.	• Continue expanding access to existing data sources at state and regional levels. • Continue developing measures and methods of application with and for C/F, staff, and partners. • Data collection uses minimal manpower thru information technology (IT) and open communication between partners in SOC. • Assure that information collected has benefit for program/system development, implementation, and/or evaluation.	• IT staff share outcome data across state agencies and with DAs while protecting client confidentiality and private health information. • CAFU and DAs maintain or develop IT informed, effective, and efficient methods of data collection, analysis, and reporting. • CAFU and DA staff use outcome data to inform their decisions about improving the system of care.
Complete statewide implementation of JOBS as transition to adult life and employment	JOBS program operates in only 7 of 10 regions.	• Fully implement JOBS in all 10 regions in collaboration with Vocational Rehabilitation, Corrections, and SRS.	• Legislative advocacy for increased funding.	• JOBS program available in all 10 regions • Increased capacity to serve more youth in JOBS in all regions.

Priority Needs	Current Status	Goals for Fiscal Year 2005 to 2007	Action Needed	Measures of Progress
Administration				
Increase compensation levels to attract and retain qualified and experienced staff in the provider system.	Although there were increases in 2001 and 2002 for DA staff salaries (5.7% and 5.4% respectively), these increases were not sufficient to offset long-standing deficiencies in compensation levels.	• Maintain cost of living. • More closely approximate state employees' levels of compensation for comparable levels of education, experience, and skills	• Continue advocacy with Legislature.	• Year-by-year increases in compensation levels
Increase levels of consumer and family (C/F) participation	There are fluctuating levels of participation across agencies, over time, and by activity.	• All DAs and CAFU have consumers and families actively engaged at the various levels of the system of care: – Individual – Program – Training – Evaluation	• Create and/or maintain a system where all staff are responsible to encourage and support consumers and families to participate in the system of care. • Develop and implement additional methods to assure healthy Program Standing Committees.	• *Individual*: goals on Individual Plan of Care (IPC) reflect consumer/family (C/F) words and signatures • *Program:* C/F on DA Board; C/F have at least 51% of active membership; C/F provide input on needed services. • *Training:* C/F participate in agency and cross-agency trainings as both audience and presenters • *Evaluation:* C/F help design program evaluation tools, complete evaluations, and are informed of results.

SECTION IV:

APPENDICES

APPENDIX A

COMPOSITE STORIES TO ILLUSTRATE THE SYSTEM OF CARE

DEVON

CHALLENGES AND DIAGNOSES

Devon, a 3 year-old boy who is an only child, lives with his biological parents. Both parents have a college education. The father is employed full-time outside the home and earns an income adequate to support the mother to stay at home to care for their children. They are awaiting the birth of their second child. The mother experienced *post-partum depression* following Devon's birth and has since often felt impatient with him. Being more active and outgoing than Devon is and somewhat mismatched to his more withdrawn temperament, she has trouble responding to his behavior. She placed Devon in child care part-time several months ago, hoping he would "blossom." Instead, he has experienced great difficulty adjusting ***(****Separation Anxiety* and *Adjustment Disorders****)***. With the mother's permission, the child care provider calls for early childhood mental health support from Children's UPstream Services (CUPS).

POSSIBLE TREATMENTS AND RESULTS

The child care provider and mother meet weekly with the CUPS worker, Theresa, and design a behavioral treatment plan to make transitions in schedule and setting more predictable and easier for Devon. His behavior initially improves. After the birth of his sister, his behavior regresses. Theresa has prepared the mother and child care provider for this predictable change. His strong emotions of jealousy and anger temporarily interfere with his ability to talk and regulate his bodily functions such as urination. With the addition of individual therapy on site at the child care center, Devon learns to express his feelings using play, words, and art. After several months, he returns to being "potty-trained."

Meanwhile, observing Devon's lack of confidence and difficulty with expression, Theresa suggests that his ability to articulate speech should be assessed. The comprehensive assessment process reveals he has a hearing problem caused by allergies. The mother works with a pediatric allergist, a hearing specialist, and a speech therapist – along with the mental health therapist – to reduce Devon's allergic response and expand his ability to communicate. She also begins to practice "Floor Time" play with him at home to draw out his feelings and thoughts.

Theresa advises the child care provider about program changes that can be made to aid the social/emotional development of all the children there. Long before he goes off to kindergarten in public school, Devon no longer needs mental health treatment or speech therapy although he continues to receive medication for his allergies.

ABOUT THE MENTAL HEALTH WORKERS

Devon's CUPS clinician is Theresa, a woman in her late thirties who just earned her Master's Degree in Community Mental Health and is new to her job. She earned this degree and her Bachelor's Degree in Early Childhood Education while working for Head Start. Theresa started out as a Head Start parent and took on increasingly responsible roles in the program over time, first as volunteer and eventually as teacher. She became interested in mental health because she observed improvements in the quality of the Head Start program as a result of the mental health consultation received by Head Start as part of its federal requirements. Now she works for children's mental health through a federal grant.

AMY

CHALLENGES AND DIAGNOSES

Amy is a 14 year-old girl with mood disorders **(***Dysthymic Disorder, Generalized Anxiety Disorder with Panic Attacks***)**. She lives with her mother (a single parent) and three siblings: one older brother (age 15) and two younger siblings (ages 4 and 2). The mother works part-time for minimum wage and receives Temporary Assistance for Needy Families (TANF). The mother drinks alcohol, often to the point of intoxication. The father of Amy and her 15 year-old brother lives out-of-state and is not involved with them. The father of the two youngest children is a long-distance trucker, and, although not married to Amy's mother, he stays with her when he is in the area. Amy was referred for outpatient mental health treatment by her physician after he learned during a routine exam that she cuts herself. Mother had told the doctor that Amy is increasingly moody and withdrawn at home. Before following through on the referral, Amy experiences a crisis.

During an argument, the father of the youngest children pushes the mother, who has been drinking and falls down. The older brother responds by assaulting the father, who then takes his children and attempts to drive away. Mother throws herself in the path of the car to keep them from leaving. Amy shuts herself in a closet and slashes her wrists. Neighbors witness the disturbance and call the police, who arrive shortly. The father says he was defending himself and his young children. Police take the older brother into emergency custody for violating the conditions of his juvenile probation (no new charges). After the police leave, the mother, father and younger children re-enter the home. They hear moaning. They find Amy, who is bleeding heavily. The father calls an ambulance. The ambulance crew arrives and takes Amy and her mother to the emergency room. A nurse there calls the community mental health center and requests an emergency screening to assess Amy's mental status and level of safety.

POSSIBLE TREATMENTS AND RESULTS

At the hospital emergency room, Amy is assessed as being at risk for suicide. The emergency mental health screener (Tom) wants to admit her to an emergency bed in a hospital diversion program; the closest one is located in another part of the state. Amy agrees to the placement at Northeastern Family Institute (NFI). Tom meets with Amy's mother to discuss the situation. The mother gives the program permission for Amy to be treated there.

While in Northeastern Family Institute's (NFI) emergency hospital diversion program, Amy is closely supervised to assure her safety. Her clinical needs are assessed and a discharge plan is developed to assure her successful return to her community. The program, Amy's local mental health center, and her mother work together with Amy to develop a community-based treatment plan. While at NFI, Amy is able to participate in individual as well as group therapy. She is seen by a psychiatrist, who recommends that she receive cognitive/behavioral therapy and medication to relieve her anxiety. Amy's physician is notified of these recommendations. The NFI staff suggest to the mental health center that Amy be assigned a case manager as well as a therapist.

The case manager, David, joins Amy, her mother, and a school representative at a discharge meeting to finalize discussion of Amy's treatment plan. The treatment plan includes a comprehensive, proactive crisis plan to help assure her safety upon returning home. During this discharge meeting, Amy's mother expresses concern about her ability to attend to Amy's needs while also attending to the needs of Amy's older brother and the two youngest children, all while working part-time.

continued

Amy, *Continued*

David stays in frequent touch with Amy and her family, helping the mother take the necessary steps to obtain Family Support Child Care for the two youngest children. David helps the mother think through the consequences for Amy of various possible decisions and actions regarding the older brother's care and the mother's relationships with the fathers of her children. He works with Amy's mother to ensure that Amy is regularly seen by her physician for receipt and monitoring of the medication. David also stays in touch with the school where Amy is a freshman. He stays alert to situations which might increase Amy's anxiety, especially stress or conflict with teachers or peers. David teaches Amy some conflict resolution and decision-making skills and practices them with her. David refers Amy and her brother to the peer support group Ala-Teen and their mother to peer support from Alcoholics Anonymous.

Amy is also assigned an outpatient therapist, Claire, at the mental health center. Amy sees Claire weekly for cognitive/behavioral therapy as well as expressive and narrative therapies. Sometimes the mother and older brother join Amy for family therapy with Claire. By the end of six months, Amy reports fewer panic attacks, less anxiety, and that she is learning to deal with the remaining anxiety by talking to herself and by turning to others for support instead of by cutting herself. The case management is stopped, but Amy continues in therapy with Claire for several more months, mostly exploring and rehearsing how to deal with high school and peer pressures, and the stresses she experiences at home. During her sophomore year she begins to skip counseling appointments. Claire calls Amy and learns that Amy feels "different" by needing therapy and wants to stop coming. Claire assures Amy that she can stop; she can also resume in the future if she wants more support. Claire helps Amy identify other people to whom she can turn, both at school and in her neighborhood. Claire also speaks with Amy's mother, saying she and Amy should not wait for another crisis to return to counseling in the future.

ABOUT THE MENTAL HEALTH WORKERS

Amy's emergency screener is Tom, who is certified by DDMHS as being a "Qualified Mental Health Professional." He is an on-call, part-time worker for the mental health center where he works as part of a children's crisis outreach team that provides 24 hour coverage 7 days a week for families in crisis in the community. Tom is in his early sixties and recently retired from full-time work as a substance abuse treatment provider. He is certified as an alcohol and drug abuse counselor and has a Master's in Social Work. He entered the field of substance abuse and mental health treatment after working for several years as a high school coach, where he became concerned about the effects of substance abuse upon youth and their families.

Amy's case manager, David, recently graduated from college with a Bachelor's degree, with a major in psychology and a minor in education. During the summer between his last two college years, he was employed at the mental health center as a community skills and respite worker. There he accompanied children who were experiencing severe emotional disturbance to summer camp and day recreational events where they needed extra support to communicate with and appropriately join the other participants in activities. He learned about the stress on families of caring for children and the importance of family support for their parents and, sometimes, their siblings. After graduation, he decided to continue working for the mental health center while considering graduate school.

Amy's outpatient therapist is Claire, who serves both children (with their families) and adults for the mental health center. She is a Licensed Clinical Mental Health Counselor with a Master's in Counseling Psychology. Her licensure allows the children's mental health program to bill the family's private insurance carrier when Claire serves a child who is not enrolled in Medicaid. She is in her mid-forties, has had this job for about ten years, and provides supervision for newer staff. She began work with the mental health center as a case manager after graduating from college; she worked full-time while earning her Master's degree. Claire supplements her income by also teaching classes about mental health at the community college.

CATHY

CHALLENGES AND DIAGNOSES

Cathy is 12 years old and has *Reactive Attachment Disorder*. Parental rights were terminated years ago due to neglect by her birth mother and sexual abuse by her birth father; her mother has cognitive limitations and her father is in jail. Cathy's maternal grandmother assumed guardianship for her daughter and adopted her granddaughter. Both the daughter and granddaughter lived with her. The grandmother died of a heart attack two years ago. Other family members notified SRS of a need for foster care for Cathy.

A suitable foster family was found. However, when the foster mother became ill, Cathy was moved to a second foster home, from which she repeatedly ran away. The SRS caseworker learned that Cathy also began skipping school. Cathy was running away from home and skipping school in order to spend time with an older boy, with whom she had become sexually involved. The SRS caseworker calls children's mental health staff for help devising an interagency Coordinated Service Plan for Cathy.

POSSIBLE TREATMENTS AND RESULTS

A children's mental health case manager, Susan, calls together a treatment team for Cathy. The team consists of Susan, the SRS caseworker, the foster mother, Cathy, and Cathy's favorite teacher. The team uses a process to identify Cathy's dreams, strengths, and challenges in all the domains of her life. The members agree that Cathy should have one-on-one attention from a highly skilled parent in order to gain or regain her ability to form trusting, normalized, non-sexualized relationships with both adults and peers.

Susan prepares a Coordinated Service Plan with an Individualized Services Budget as an avenue to obtain the necessary interagency authorization and funding for Cathy's intensive wrap-around services. The services include placement for Cathy in therapeutic foster care with respite support for the foster parents, individual and family therapy by Claire, a mental health outpatient therapist for Cathy and her new foster family, group therapy for sexually-abused pre-adolescent girls, and community integration during after-school and vacation hours to improve Cathy's socialization and communication skills with peers. The treatment plan includes incentives for expected behavior, consequences for undesirable behavior, and supervised contact between Cathy and her birth mother as Cathy wishes. A proactive crisis plan is also an important part of Cathy's overall plan. The plan is approved, funded, and continues for over a year.

A children's mental health Community Skills Worker, Martha, provides the community integration, respite, and supervision for Cathy's visits with her birth mother. The community integration includes support and supervision for Cathy to participate in youth group events organized by Susan. The community integration and outpatient therapy are gradually reduced over the following months as Cathy enters high school and becomes active in extra-curricular activities there. The foster parent chooses to stop providing therapeutic foster care and to adopt Cathy, with the aid of an ongoing adoption subsidy from SRS for families adopting children with special needs. This subsidy allows the parent to privately purchase Martha's time for supervision of Cathy during visits with her biological mother and during planned care-giving breaks (respite) for the adoptive parent.

ABOUT THE MENTAL HEALTH WORKERS

Cathy's case manager, Susan, is stationed in the SRS district office. She is a children's mental health case manager and receives clinical supervision from the mental health center. Her position was jointly funded by SRS and mental health three years ago. Susan came to that new position after having been a counselor for a runaway and homeless youth program for two years. In her late twenties, she is an avid hiker and biker and likes to organize camping and other activities for youth. She majored in drama and minored in psychology in college, earning a Bachelor's Degree. She supervises hourly workers who provide community integration services for children and youth in accordance with their treatment plans.

continued

Cathy, *Continued*

Cathy's community skills worker, Martha, is in her mid-fifties; she provides both community integration and respite services for children and families served by children's mental health. Since her own children have grown up and moved away, she satisfies her desire to care for others and to spend time with children through this work for mental health. She also works for mental health monitoring the use of medications by children and adults. She is a Registered Nurse who suffers from back problems that prevent her from lifting medical patients; she is able to continue with her nursing career in this part-time way. In this role, she has occasionally offered training to mental health staff in first aid, protection from blood-borne pathogens, and other medically-related topics.

SAM

CHALLENGES AND DIAGNOSES

Sam is a 9 year-old boy with *Attention Deficit Hyperactivity Disorder (ADHD)* and *Oppositional Defiant Disorder*, which are especially evident at school. His parents are divorced with joint custody. Sam spends half his time with his mother and a younger brother, and the other half of his time with his father and his father's new wife and baby. Sam's parents are bitter about, and disappointed with, each other. However, they have participated in court-ordered divorce education and mediation, and recognize the importance of putting their children's well-being ahead of their own resentments. They know Sam is unhappy and needs help coping with their divorce. They both work but have limited funds for mental health treatment and are worried about the stigma of needing and/or receiving such treatment for their child. Sam's school assigns a mental health worker for him and both his parents/families.

POSSIBLE TREATMENTS AND RESULTS

The school team identifies Sam as a child who might have an emotional disability. They obtain permission from Sam's parents to test him for eligibility for Special Education. The permission includes observation of Sam in the classroom by Betsy, a mental health worker. Betsy observes Sam, and then meets with his parents and the rest of the school team for a discussion of Sam's strengths and challenges at school.

Betsy suggests that Sam be seen by his physician for a physical check-up and possible medication. Mother says the physician has not shown much concern about Sam's behavior in the past. Betsy tells her about the psychiatric consultation now available to physicians through the Office of Vermont Health Access (OVHA). The parents agree to follow-through on her referral for a check-up, and ask their pediatrician to refer Sam for a psychiatric consultation, which he does. They go together with Sam to meet the psychiatrist, who also discusses with the parents various implications of research indicating that ADHD and Oppositional Defiance are conditions which tend to be genetic in origin. The psychiatrist then consults with Sam's pediatrician who subsequently recommends counseling and prescribes medication for Sam.

The rest of the school testing indicates that Sam is eligible for Special Education and entitled to an Individualized Education Plan (IEP). Both parents meet with the school team, including Sam's teacher, to develop the goals and objectives for the IEP and the related Act 264 Coordinated Service Plan for Sam. This Act 264 plan, which Betsy prepares, looks at Sam's needs across his three environments: the school and his two homes. It includes the mental health treatment for Sam, particularly the behavioral expectations. Sam's parents and teacher agree to uphold the same rules and to enforce similar consequences, focusing on positive behaviors as much as possible. They meet with Betsy monthly at first, then quarterly, to monitor their implementation of the plan.

continued

Sam, *Continued*

In addition to structuring this behavioral treatment, Betsy meets with Sam weekly at school for one class period. At that time he is invited to express his feelings through play, art, movement, and words. Betsy mirrors Sam by playing a game with him and/or by active listening. Betsy also gathers together a small group of other children also affected by divorce. They meet after school for one afternoon a week in group therapy, playing and talking together. This builds Sam's socialization skills and network of friends.

Gradually the medication helps Sam feel more relaxed and attentive; the increased consistency in his environments reduces his anger, and he learns to express his feelings in ways that do not anger others. His behavior and his grades improve.

ABOUT THE MENTAL HEALTH WORKERS

Sam's school mental health clinician, Betsy, works as part of a team consisting of herself, the school guidance counselor, the school nurse, and the school social worker. While Betsy works at the school, she also has an office at the community mental health center, where she receives clinical supervision. Her therapist position was jointly funded by the school and the community mental health center six years ago. Betsy is the third person to fill that position; the second person was hired by the school and became the school social worker. Betsy came to this job two years ago fresh from college, where she had earned a Bachelor's Degree in Education and a Master's in Social Work. She is in the process of applying to doctoral programs in psychology in order to learn more about and practice more psychological testing.

APPENDIX B

Vermont System of Care for Children and Adolescents
With a Severe Emotional Disturbance and Their Families

2004 PRIORITIES:

The Vermont Advisory Board for Children and Youth with Special Mental Health Needs (Act 264 Advisory Board) supports the Governor's attempt to provide a safety net for Vermont's children and adolescents with serious mental health needs.

The Board urges the state to focus on two strategies.

1. Focus on early childhood to turn the curve on improved outcomes.

a) Replace $600,000 in federal grant funds to continue successful CUPS services as proposed in the Governor's budget.

b) Fold early education costs into the Special Education funding formula.

c) Work with the Child Care Division and Department of Education to streamline the approval process for early education programs located in public schools.

d) Implement the Pediatric Collaborative request from DDMHS, DH, and SRS to expand EPSDT Medicaid coverage for screening from the current ages of 0 to 3 to the ages of 0 to 6.

e) Support research and evaluation on why children are harming themselves and others at much younger ages.

2. Increase funds for mental health salaries to assure an adequate base for the system of care.

The foundation of Vermont's public system of community mental health centers is in a downward spiral due to staff salaries that are not competitive in today's job market.

- Most centers experience a 20+% annual rate of staff turnover.
- Salaries are not comparable to those for SRS employees or education emplo yees with similar degree and credentialing requirements.
- There is no cost of living adjustment, and most centers have had to cut back on benefits in the last several years.
- Many experienced staff move to positions in the SRS and the education systems to pay off their education loans and support their families.
- Recruitment is becoming more difficult, with very low response rates to openings. This can result in vacancies for extended periods of time, even though the agency may have a waiting list for services.
- The centers have more young staff with less experience.

This results in two serious implications for the foundation of Vermont's system of care:

a) Successful therapeutic relationships between consumers and staff are built on trust. Long waits for needed services or repeated changes of a child's therapist or case manager undermine trust and the possibility of success.

b) Long waits or concern about the limited experience of staff can cause SRS and education agencies to turn to other private agencies for services. This can de-stabilize Vermont's integrated system of care.

Vermont's mental health system for children depends on the use of federal Medicaid funds. To access these Medicaid dollars, mental health has turned to SRS and education to provide the required state match of general fund dollars. With this strategy, Vermont has successfully used federal Medicaid to pay for a substantial portion of the mental health services it provides to children and adolescents. Without SRS and education as sources of general fund match, (1) the mental health service system's capacity will shrink significantly and (2) the general fund cost to SRS and education for the same services will increase dramatically without the Medicaid input.

ACT 264 BACKGROUND INFORMATION

1. Act 264

In 1988 the Vermont Legislature passed Act 264. The purpose of this law is to develop and implement a coordinated system of care so that children and adolescents with a severe emotional disturbance and their families receive the appropriate services and supports within the child's coordinated services plan.

2. Advisory Board

The Governor-appointed Advisory Board consists of nine members including equal numbers of parents, advocates, and providers. The Board's purpose is to advise the Secretary of the Agency of Human Services and the Commissioners of the Departments of Developmental and Mental Services, of Social and Rehabilitation Services, and of Education on:

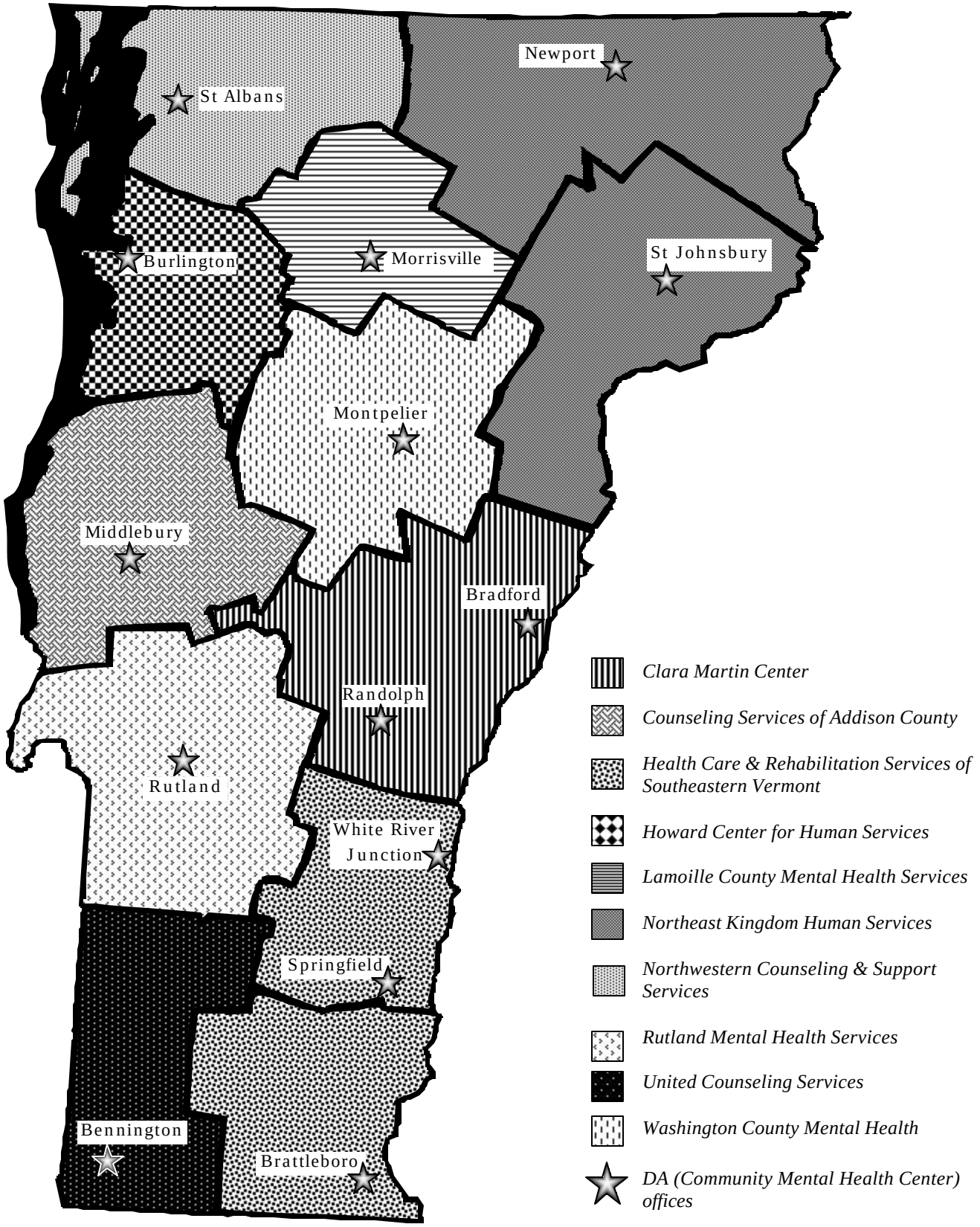
- matters relating to children and adolescents with a severe emotional disturbance;
- the development and status of the system of care; and
- yearly priorities on the system of care for submission to the legislature.

3. Current Board Members

Diane Janukajtis, Chair Stannard	Deborah Turner Groton	Diane Dexter Calais
Guy Wood Putney	Jeff McKee Rutland	Jo-Ann Unruh Hartford
Kreig Pinkham Northfield	Sherry Nelson St. Albans Bay	[one vacancy]

APPENDIX C

DESIGNATED AGENCIES BY REGION



APPENDIX D

PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH: GOALS AND RECOMMENDATIONS

(http://www.mentalhealthcommission.gov/reports/Finalreport/FullReport.htm)

President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America Executive Summary

Vision Statement

We envision

a future when everyone with a mental illness will recover,

a future when mental illnesses can be prevented or cured,

a future when mental illnesses are detected early, and

a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

GOALS AND RECOMMENDATIONS IN A TRANSFORMED MENTAL HEALTH SYSTEM...

Goal 1	**Americans Understand that Mental Health Is Essential to Overall Health.**	
	Recommendations	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 1.2 Address mental health with the same urgency as physical health.
Goal 2	**Mental Health Care Is Consumer and Family Driven.**	
	Recommendations	2.1. Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery. 2.3 Align relevant Federal programs to improve access and accountability for mental health services. 2.4 Create a Comprehensive State Mental Health Plan. 2.5 Protect and enhance the rights of people with mental illnesses.
Goal 3	**Disparities in Mental Health Services Are Eliminated.**	
	Recommendations	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**	
	Recommendations	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**	
	Recommendations	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**	
	Recommendations	6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations. 6.2 Develop and implement integrated electronic health record and personal health information systems.

APPENDIX E

ENDNOTES

[1] Unless otherwise noted all references to years are to Vermont State Fiscal Years. Thus July 1, 2002 through June 31, 2003 is Vermont State Fiscal Year 2003.

[2] US Department of Health and Human Services. (1999) *Mental Health: A Report of the Surgeon General – Executive Summary*. US Public Health Service: Rockville, Maryland.

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[4] SAMHSA. (07/17/98) Children with Serious Emotional Disturbance: Estimation Methodology. *Federal Register*. Vol. 53. No. 137. pp. 38661-38665.

[5] Hogan, C., & Hull, M. (January 15, 1997) *Services to Vermont's Children and Adolescents with Emotional or Behavioral Challenges: Moving to the Year 2000*. Agency of Human Services and Department of Education, Vermont. pp.11-13.

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[8] Pandiani, J., Bramley, & J., Pomeroy, S. (December 2002).

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[13] Pandiani, J., Bramley, J., & Pomeroy, S. (December, 2002).

[14] Libertoff, K. (October 4, 2002) *2003 Social Policy Priorities.* Vermont Association for Mental Health: Montpelier, Vermont.

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[17]Pandiani, J. & Bramley, J. (January 9, 2004) *Vermont Mental Health Performance Indicator Project (PIP) Report on Child and Adolescent Caseload Segregation/Integration in Vermont FY1993-2003*: The State of Vermont Department of Developmental and Mental Health Services: Waterbury, Vermont.

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[19]Livingston, J.A. (1994). *Respite care program for youth experiencing severe emotional disturbance and their families: Evaluation report.* Waterbury: Vermont Department of Developmental and Mental Health Services.

[20]Bruns, E. & Burchard, J. (2000) *Impact of respite care services for families with children experiencing emotional and behavioral problems.* Children's Services: Social Policy, Research and Practice, 3(I). pp 39-61.

[21]Clark, H. B. & Deschenes, N. (4/8/02). *Transition to Independence Process (TIP) System: Guidelines for the Development and Operation of a Transition System of Youth and Young Adults with Emotional/Behavioral Difficulties.* http://www.fmhi.usf.edu/cfs.policy/tip/tipsystem/tipsystem.htm.

Appendix F

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Appendix G

GLOSSARY

Act 264: Vermont law passed in 1988, adding Chapter 2 to Title 3 V.S.A. and sections to related titles in order to develop and implement a coordinated system of care for children and adolescents with a severe emotional disturbance and their families. Act 264 defines severe emotional disturbance and creates an Advisory Board and State and Local Interagency Teams to assist in the provision of care through the use of a coordinated service plan for children served by more than one agency.

Adjustment Disorder: Defined in DSM-IV-TR (code #309 range) as the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

Administrative Rules on Agency Designation: Formally adopted regulations for implementing Vermont mental health law (18 V.S.A., chapter 207) designating community mental health agencies. These rules were most recently revised effective June 1, 2003.

Agency of Human Services (AHS): The largest unit within the Executive Branch of Vermont State government, the AHS includes the Departments of: Aging and Disability (DAD); Corrections (DOC); Developmental and currently Mental Health Services (DDMHS); Health (DH); Prevention, Assistance, Transition and Health (PATH); and Social and Rehabilitation Services (SRS). AHS also includes the Offices of Economic Opportunity (OEO) and of Child Support (OCS).

Alcohol and Drug Abuse Programs (ADAP): The Division of ADAP is part of the Vermont Department Health and has responsibility for preventing and treating substance abuse by Vermonters.

Appropriation: Funding approved by the legislature for a department, program, or particular expense.

Attention Deficit Hyperactivity Disorder (ADHD): Defined in DSM-IV-TR (code #314 range) as a persistent pattern of inattention and/or hyperactivity that is more frequently displayed and more severe than is typically observed in individuals at comparable levels of development. Some symptoms must have been present before 7 years of age.

Autistic Disorder: Defined in DSM-IV-TR (code #299.00) as the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests.

Blood-borne pathogens: Disease-causing micro-organisms carried in the blood (*e.g.*, hepatitis, HIV). Mental Health staff are trained to protect themselves and clients from these and other health hazards.

Child, Adolescent and Family Unit (CAFU): This Unit and the Adult Unit comprise the Division of Mental Health (DMH) of the DDMHS. The CAFU staff (10 FTE) oversee Vermont's mental health system of care for children described in this plan.

Caseload integration: A measure of caseload overlap.

Caseload overlap: This condition exists when different departments share the same client on their caseloads.

Causative factors: Agents that cause other things to happen.

Child-centered: The child is a center of focus.

Children's UPstream Services (CUPS): A six-year grant from the federal Center for Mental Health Services to expand mental health services for children (aged 0-6 and for young parents under 22) with serious emotional disturbance and for their families. The grant also provides mental health consultation and training for child care and other direct service providers for young children.

Collaborative: Together, jointly with others.

Competencies: Skills, abilities.

Composite: A fictional person based on various aspects of real people and their lives.

Continuous Quality Improvement: A comprehensive approach to quality control and management that grew out of work by Dr. W. Edward Deming who said to give customer concerns top priority, and to study and constantly improve every work process so that the final product or service exceeds customer expectation.

Coordinated Service Plan: Defined by Act 264, this is an interagency tool for identifying the goals, strengths, services and funding needed for a child with severe emotional disturbance, and also the unmet service needs. This Plan is a written addendum to the service plan developed for the child by each agency serving him/her.

Core Capacity Services: This is the minimum range of children's mental health services for which DDMHS contracts with each DA.

Cultural diversity: The variety of behavior patterns, arts, beliefs, institutions and other characteristics expressed in a community by different populations.

Department of Developmental and Mental Health Services (DDMHS): This AHS Department designates, funds, monitors and provides technical assistance for community non-profit agencies to deliver services to Vermonters with serious and persistent mental illness, severe emotional disturbance, developmental disabilities, and/or mental health crises.

Department of Education (DOE): This free-standing State Department licenses teachers, approves funds, and provides technical assistance for schools to educate children from pre-kindergarten through high school graduation and oversees Adult Basic Education programs.

Developmental Disabilities: This term is defined by Vermont's Developmental Disabilities Act of 1996 (adding 18 V.S.A. chapter 204A) and the related regulations of 5/15/97. DDMHS services for people with developmental disabilities are described in the *Vermont State System of Care Plan for Developmental Services, Fiscal Year 2003 Update*.

Division of Mental Health (DMH): This Division and the Division of Developmental Services, along with the business, legal, and information system divisions, comprise the DDMHS. The DMH services for adults are described in *The Statewide System of Care Plan for Adult Mental Health in Vermont, Fiscal Year 2002-2004*.

Designated Agency (DA): As specified in the *Administrative Rules on Agency Designation*, the Commissioner of DDMHS shall designate one agency in each geographic area of the state to assure that people in local communities receive services and support that are consistent with available funding, the State System of Care Plan, the local System of Care Plans, outcome requirements, *etc*.

Designation Review: As specified in the *Administrative Rules on Agency Designation*, the process for initial and re-designation of an agency by the DDMHS consists of multiple steps and levels of review that must occur at least once every four years to assure the contracted agency meets or exceeds required levels of quality.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR): Produced by the American Psychiatric Association, this manual reflects research and the consensus of experts about how to classify and describe mental disorders.

Domains of Quality Service: The items chosen for ongoing measurement to guide management of DDMHS have been grouped as follows for easy reference: (1) access to care, (2) practice patterns of care, (3) outcomes/results of treatment, and (4) structure/administration.

Dysthymic Disorder: Defined in DSM-IV-TR (code #300.4) as a chronically depressed mood that occurs for most of the day for more days than not for at least 2 years. For children and adolescents, instead, there may be a chronically irritable mood that occurs for most of the day for more days than not for at least 1 year.

Emotional Disability (ED): Generally, a problem involving a person's emotions and/or behaviors. Technically, as defined in federal IDEA legislation (Individual with Disabilities Education Act), an emotional disturbance exhibited over a long time and to a marked degree may be documented as a disability allowing school accommodations under a 504 Plan. If the disability has an adverse effect on educational performances and there is a need for special education that cannot be met by existing school services, a student may be eligible for special education and an IEP (Individual Education Plan).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT was enacted by Congress to reduce infant mortality and improve access to child health services. It mandates that a comprehensive set of services be available to children enrolled in Medicaid. An individual child may use a particular service if it is prescribed by a licensed practitioner as medically necessary.

Families First (Access Vermont/Family Preservation Initiative): Initially a five-year grant from the federal Center for Mental Health Services, this initiative has been sustained with a mix of state general funds and Medicaid to provide crisis outreach services for families whose children are at risk of removal from their homes and/or communities.

Family Support Child Care: The cost of child care is paid for families assessed to be at risk of abusing and/or neglecting their children. Funding is provided if the family participates in a plan for services to reduce its stress.

Floor Time: A method for reciprocal interaction with a young child recommended by Dr. Stanley Greenspan to develop the child's communication skills and to build attachment between the child and his/her caregiver.

Full-Time Equivalent (FTE): A full-time employee for a DA works 37.5 hours per week. Employees' time is often pro-rated across different positions (*e.g.*, clinician and supervisor), and multiple part-time employees may fill one position (*e.g.*, 4 respite workers may work a total 37.5 hours in a week between them).

Fiscal Year (FY): For business purposes, the State of Vermont claims July 1-June 30 to be its fiscal year.

Generalized Anxiety Disorder (with or without Panic Attacks): Defined in DSM-IV-TR (code #300.02) as excessive anxiety and worry (apprehensive expectation) occurring more days than not for a period of at least 6 months, about a number of events or activities.

Grants: Funds bestowed on a formula or competitive basis to organizations for specific purposes as agreed between the funder and the grantee.

Health Department: This AHS Department plans and implements primary prevention programs (such as smoking cessation) targeted to improve the health of whole communities and populations in Vermont, as well as programs targeted to special groups like low-income mothers with babies or people with AIDS.

Holistic: Emphasizing the importance of the whole and the interdependence of its parts.

Ibid: Note indicating that the quoted material can be found in the book, article or paper cited in the previous footnote.

Individualized Education Plan (IEP): Federal and state law entitles all students, including those with disabilities, to receive a free, appropriate public education (FAPE). An IEP is an important tool for ensuring the appropriateness of that special education for qualified students. An IEP identifies and monitors progress toward learning goals and objectives for the student, based upon a comprehensive assessment and input from the student's team, which includes at least parents and teachers.

Individualized Services Plan: This mechanism is used by DDMHS in collaboration with one or more other departments (usually SRS) to plan and budget for the multiple services required by particular youth with intensive needs. DDMHS approves the related Medicaid expenditures in accordance with the state general funds provided as match by the other department.

Jump on Board for Success (JOBS): This is a partnership among Vocational Rehabilitation, DDMHS, Corrections, and SRS, to expand services and employment outcomes for youth with SED who are transitioning to adulthood. JOBS was developed by the Washington County Mental Health Services in 1992 and has since been replicated by 6 other DAs in Bennington, Burlington, Morrisville, Newport, St. Albans, and St. Johnsbury.

MAPS: The McGill Action Planning System for helping a team identify with a student his/her history, dreams, fears, strengths and needs in order to develop a plan for action.

Match: State general fund dollars needed to access or draw down federal Medicaid dollars. The exact ratio is adjusted periodically by an economic formula, but Vermont's ratio is roughly 1:2. For every $1.00 of general funds Vermont pays as match, DDMHS can draw down approximately $2.00 additional in federal Medicaid to help pay for medically necessary services.

Medicaid: Title XIX of the federal Social Security Act creates Medicaid as an entitlement to medical care for people who are aged, blind or disabled or who have low-incomes and children. This entitlement is funded partly (about 50-60%) by the federal government and partly (about 40-50%) by the states. Each state decides what services to cover and for whom, based upon projected expenses and social priorities.

Office of Vermont Health Access (OVHA): This Office is part of the Department of PATH, and it manages the State's Medicaid funding available for reimbursing the approved doctors, nurses, therapists, and others who provide medically-necessary services for Medicaid-eligible children and adults.

Oppositional Defiant Disorder (ODD): Defined in DSM-IV-TR (code #313.81) as a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persists for at least 6 months.

Paraprofessionals: Assistants to professionals.

Partnership: An association of organizations or people cooperating with each other in an activity of common interest.

Perinatal: The period of time ranging from 28 weeks after conception to 28 weeks after birth.

Postpartum depression: Defined in DSM-IV-TR as a mood disorder with onset within 4 weeks after childbirth. The mood disorder for the mother in Sam's story could be Major Depressive Disorder, Single Episode (code #296.2X), with postpartum onset. If so, for at least two weeks she would have experienced depressed mood and/or loss of interest and pleasure, with multiple other symptoms.

Prenatal: Before birth.

Prevention, Assistance, Transition, Health Access (PATH) Department: This AHS Department (previously called DSW or Department of Social Welfare) administers the federal Temporary Aid for Needy Families (TANF) funds, and the Reach-Up help for families receiving TANF. PATH also determines the eligibility of individuals for Medicaid and other assistance (*i.e.*, for food or fuel). PATH includes OVHA.

Pervasive Developmental Disorder (PDD): Defined in DSM-IV-TR (code #299 range) as a group of disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interest and activities. PDD includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD Not Otherwise Specified.

Preferred provider system: A method for managing the quality and cost of care by paying only certain providers to deliver services. According to Vermont law, DDMHS must use such a system. For DDMHS, the preferred providers are the DAs.

Prevalence: Generally, the rate of occurrence of a condition. The federal estimate of the prevalence of serious emotional disturbance among Vermont's children and youth is conveyed in the Federal Register for July 17, 1998.

Program in Community Mental Health (PCMH): This is a certificate and Master's Degree program now administered by Southern New Hampshire University, formerly by Trinity College. PCMH was created with extensive involvement and support from the DDMHS and the DAs, which have a continuing need for staff educated about effective approaches to community-based public mental health care.

Program Review: CAFU visits each DA's children's mental health program every two years to review records and meet with staff, administrators, stakeholders, and parents of children served. These constituents are asked about the strengths and challenges of the program and for their recommendations. The CAFU then produces a written summary of what it learns and asks the DA to respond to the findings within a context of continuous quality improvement. Fundings are also incorporated in the designation process.

Psychiatric nurse practitioner: A Registered Nurse with a Master's Degree in Nursing who is allowed in Vermont to prescribe medications if s/he works in consultation with a licensed physician. Some nurse practitioners are also nationally certified to work with patients with psychiatric conditions.

Psychological testing: The use of valid and reliable ways of examining the mind or emotions.

Qualified Mental Health Professional (QMHP): A QMHP is designated by the Commissioner of DDMHS to screen people for voluntary admission and to serve as the applicant for involuntary admission to the Vermont State Hospital and designated general hospitals. Designation as a QMHP depends upon qualification, demonstrated knowledge and training, and completion of a DDMHS application.

Quality Improvement (QI) Plan: *The Administrative Rules on Agency Designation* require an annually-updated QI Plan from each DA, reporting on the DA's use of agency data and outcomes, changes in objectives, timelines, and scope of planned projects for the year.

Reactive Attachment Disorder of Infancy and Early Childhood: Defined in DSM-IV-TR (code #313.89) as markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care.

Residential case review: The process of determining whether or not a child's best treatment interests would be met in a residential placement involves application for such a placement through the Central Review Committee (CRC) of the Act 264 State Interagency Team. SRS, DOE, CAFU, and the Vermont Federation of Families for Children's Mental Health are represented on the CRC. CRC considers applications from SRS, DOE, and the DAs on behalf of the Act 264 Local Interagency Teams and/or treatment teams for individual children, youth, and their families.

Resiliency: The capacity to bounce back from misfortune or illness, to be restored to an earlier condition or shape.

Respite: Temporary rest or reprieve from the stress of care-giving.

Separation Anxiety Disorder: Defined in DSM-IV-TR (code #309.21) as developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

Serious Emotional Disturbance (SED): The federal definition for serious emotional disturbance is conveyed in the Federal Register for May 20, 1993.

Severe Emotional Disturbance: Act 264 embeds into Vermont law a definition for severe emotional disturbance that is essentially (with slight changes) the federal definition for SED. The definition includes diagnostic and functional elements relevant for children and youth aged 0-22 in Vermont. Children with SED experience mental health symptoms that seriously impair their functioning and comfort.

Social and Rehabilitation Services (SRS) Department: This AHS Department includes the Divisions of Child Care Services and of Social Services, as well as Disability Determination. The Division of Child Care Services licenses or registers, monitors, and provides technical assistance for child care centers and day care homes. Group homes for older children are also licensed. The Division of Social Services monitors the placement in foster or group homes, kinship homes or treatment settings for children in State custody. SRS is given custody of children upon court findings of abuse, neglect, unmanageability, and/or delinquency. Their mission is to assure the safety and well-being of each child with a permanent caregiver/parent.

Socialization skills: Abilities (like communicating, sharing, waiting and understanding behaviors of others) needed to take part in social situations.

Specialized Service Agency: As specified in the *Administrative Rules on Agency Designation*, if a needed service is not available through a DA, the DDMHS may contract with another organization to provide it if the agency meets the requirements of a Specialized Service Agency. Such an Agency must offer services that meet distinctive individual needs or take a distinctive approach to service delivery and/or coordination.

Stakeholders: People with legal, financial or other interests in the outcome of a program or undertaking.

Step-down: To gradually reduce the intensity of service by moving from a hospital to a structured residential placement before moving home.

Strengths-based: This treatment principle asserts the benefits of building on the strengths of a child or family, rather than focusing solely on their "deficits" or problems.

Success Beyond Six: This is a funding partnership between DAs and schools whereby schools provide the state general funds to match Medicaid, the DAs provide access to Medicaid, and the schools and DAs jointly hire children's mental health staff for a variety of programs which serve children referred by the schools.

System of Care: A set of ideas, principles, rules, procedures, services and supports that are interrelated and that interact as a whole to ensure that children and adolescents with an emotional disturbance and their families receive services and supports needed to help them grow into caring, competent and responsible citizens.

Temporary Assistance for Needy Families (TANF): This is cash assistance available on a short-term basis for families with children that have low incomes and meet work and/or other requirements.

Trauma: A wound or emotional shock that produces substantial and lasting psychological/physical damage.

Unconditional care: Absolute, unrestricted commitment to protection, supervision and treatment for eligible children and their families.

Vocational Rehabilitation (VR) Division: This Division is part of the AHS Department of Aging and Disability (DAD), which oversees services for adults who are elderly and/or disabled. VR helps adults and teen-agers (transition-aged youth) with disabilities prepare for and obtain employment suited to their interests, knowledge, and skills.

Waiver: The Home and Community-based Waiver is a federal release from (or waiving of) the usual rules governing fee-for-service Medicaid. The Waiver allows more flexibility in the definition and delivery of services for people at risk of institutionalization under the condition that the cost of services provided under the Waiver does not exceed the cost of institutionalization.